

Client contact details

Name: _____ Date of Birth: _____ M/F _____

Address: _____

Post Code: _____

Contact numbers: Day: _____ Eve: _____ Mobile : _____

In case of an emergency

Name: _____ Number: _____ Relationship: _____

Client lifestyle details

Occupation: _____ Lifestyle: _____

Number of children: _____ Special considerations: _____

GP details

Name: _____ Number: _____

Surgery address: _____

Medical History

Do you or have you ever suffered from any of the following condition? if answer is yes to any please give details below.

Impetigo	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fractures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lymphangitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lice & Mites	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Acute sprain/strain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Systemic Oedema	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Herpes simplex	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bursitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Athletes foot	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Osteoarthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ringworm	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Varicose veins	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Shingles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Warts/Verrucae	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glandular fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Multiple Scierosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Eczema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thrombosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Parkinson's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Psoriasis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Very low BP (<100/60)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dermatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Atherosclerosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Acne/Boils	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recent Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Burns	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Bruising	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Haemophillia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Undiagnosed lumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Open cuts/ wounds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Substance abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Details: _____

Has permission been given by the GP/Consultant to carry out the treatment? Yes No (please attach letter)

Have you visited your GP in the last 6 months? Yes No Details: _____

Are you on any prescribed medication? Yes No Details: _____

Are you receiving treatment from another professional? Yes No Details: _____

Do you suffer from allergies? Yes No Details: _____

Do you have any medical conditions other than those listed above? Yes No Details: _____

I hereby confirm that the information stated above is answered to the best of my ability. I further understand that thorough and honest responses to these questions are essential to my safety. I undertake to inform my therapist should any answers to the above information change.

Signed: _____ Date: _____